CITY OF SOUTH BEND
LIABILITY CLAIM FORM

(Please write or print clearly)

CLAIMANT NAME: _____ **Telephone:** _____

Address: _____
Number Street City State Zip

Date and Time Loss occurred: _____

Location loss occurred: _____

Extent of loss: (Please provide two (2) written estimates for property damage): _____

Describe what happened: _____

Names of person(s) involved (if known); _____

Amount of damages sought: _____

Claimant's residence at time of loss: _____

Signature: _____ **Date:** _____

Please mail or bring to:

City Attorney's Office
Attn: Claims Department
227 W Jefferson Blvd., Suite 1400
South Bend IN 46601

(Web Form)